



GAPNA Section

Have you considered a house calls practice?

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There are currently more than 40 million people over the age of 65 in the United States. Many of these Older Adults find it difficult to leave home for a variety of health and psychological reasons including multiple and complex chronic conditions such as heart disease, lung disease, diabetes, pain, depression, cognitive and mobility impairments or lack of caregiver support. Where do these patients receive their health care and in what setting makes the most sense for these frail individuals? What happens when a patient is unable to get into a traditional office practice for routine medical care and follow-up? Multiple studies suggest they end up in the ER or hospitalized for conditions that could have been prevented with earlier diagnosis and treatment. Many receive futile care that is not in-line with their values or consistent with the trajectory of their decline because of the absence of a health care directive. One current National health care focus is on developing ways to prevent avoidable hospital readmissions as well as associated costs not only in dollars and cents but in the human burden of suffering that accompanies frequent hospitalizations and ER visits. Atul Gawande, in his January 24, 2011 New Yorker article “The Hot spotters” discusses the savings to be had while providing excellence in Primary Care by concentrating on the sickest, highest cost users of health care... those who are most often homebound and currently receiving their “primary care” in the ER and hospital settings.

For all of these reasons, House Calls are a rapidly growing arena for Nurse Practitioner involvement. Whether it's running an independent House Calls Primary Care Practice full time, or whether it's scheduling a few visits to homebound patients from a regular clinic or office practice, these visits to Older Adults in their home settings are a valuable benefit to our communities that will extend the spectrum of health care services and improve access to care for frail Older Adults.

This venue for NP practice providing longitudinal care in the home setting is also rewarding and multi-dimensional. Given our

training and whole-person focus, NPs are well-suited to provide the type of coordinated care that these complex patients, their families and caregivers need. In addition to potentially reducing avoidable Hospital admissions and ER visits, NP Home visits can provide a myriad of services to keep patients well and residing safely in their homes. From Personalized Prevention Plan Services (PPPS) and Annual Wellness Visits (AWV) to treatment of acute illness and management of complex co-morbid conditions, the ability to work with patients and their families in the home setting is truly where the “Medical and the Social Meet”. It is an opportunity to thoroughly know a patient and his or her support system and to genuinely make a difference in not only their overall health but their quality of life.

This series of articles written by NPs who are working in the field of Home Based Primary Care will showcase various models and individuals who deliver Primary, Preventative, and Palliative Care to frail older adults in their home settings. Health care reform has opened up new venues for reimbursement as well as opportunities to grow this field to meet the needs of those it serves. Many opportunities are also developing to work with Hospital Systems, Accountable Care Organizations, and programs for Dual-eligibles to reduce risk in chronically ill patients by providing case management and transitional care. Perhaps those of you reading these articles will be inspired to develop a program that serves the needs of this population in your own communities. The need is strong and the methods of development are varied, being limited only by one's time and imagination.

1. Model one : Sharri Rittenhouse, NP

Mrs. Rittenhouse, or Sharri, which she prefers to be called, is responsible for performing H & Ps and managing chronic disease states while serving as the PCP for homebound patients. She currently carries a caseload of approximately 300 homebound patients throughout Metro Atlanta. Her patients are from diverse cultural backgrounds with complex diseases such as COPD, Dementia, Parkinson's, heart failure, stroke, and diabetes amongst many other debilitating internal medicine diseases. Sharri provides primary and urgent care to patients, at their places of residence – mainly in their homes and Assisted Living Facilities.

Sharri acts as a change agent and case manager to ensure patients and their families receive the best care possible. She strives to provide seamless holistic care to patients and families. While using up to date research to continuously improve care she coordinates her care with interdisciplinary teams and community home health agencies for continuity to help avoid recurrent ER visits and hospitalizations to maintain cost-effectiveness. She is affiliated

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with two feeder hospitals in her area. Most of her reimbursement comes from Medicare or other private insurances. She also makes it clear that properly billing Medicare for Home Health and Hospice Care Plan Oversight (CPO) is one important way to ensure that time spent coordinating patient care is reimbursed and does overall help practice sustainability.

Two years ago Sharri arranged a site visit to Dr. Cornwell's, President Elect of the American Academy of Home Care Physicians (AAHCP), house calls program in Chicago to obtain operational information and observation. Upon returning to Atlanta she aligned her House Calls program to compete as an "Independence at Home" Demonstration Project site and was recently selected by CMS to participate. She also participated in CMS open door forums and provided input about referral sources, quality measures, e-prescribing incentives, remote monitoring and diagnostic testing. She states one of the biggest barriers she encounters to the provision of care to her geriatric patients is her inability to sign for Medicare Certified Home Health services and is eager for passage of the Home Health Planning and Improvement Act S. 227 and H.R. 2267, hopefully this year.

Among her many other roles and activities Sharri has also been responsible for spear-heading the development of a new Physician House Call program under a prominent home health agency. She led and participated in the grassroots administrative efforts including building the infrastructure of the program even down to selecting the EMR that was used. A few years prior, Sharri provided services similar to this for homebound Veterans. Because she is also a Veteran of Operation Desert Shield, she felt well suited to relate to the soldiers' situations. She is an active member of GAPNA, AAHCP, and the United Advanced Practice Registered Nurses (UAPRN). This past September she received the GAPNA award for Excellence in Clinical Practice 2012.

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Lesbian, gay, bisexual, and transgender (LGBT) elders in nursing homes: It's time to clean out the closet

Jennifer Serafin, GNP-C, George Byron Smith, DNP, ARNP, GNP-BC, CNE, Trudy Keltz, GNP

At the GAPNA National Conference in Washington, D.C., a group of Northern California Chapter members were discussing a newspaper article. It was from a local paper in Oakland, California,

discussing how elders in the Bay Area were keeping their LGBT status secret when they entered into a nursing home.¹ This was despite the fact that prior to their admission to the Nursing Home, they had been living openly as LGBT. This article caused quite a discussion among our chapter, as the Bay Area is usually quite accepting of LGBT people, especially in San Francisco. Many of us were shocked that this was occurring.

One of our colleagues admitted that about 10 years ago, she was discussing this exact thing with a friend. While she previously thought that she had never known any LGBT patients, it dawned on her that she had to have known someone who was LGBT at some point. Of course, it was the same issue: LGBT patients choose to hide their sexual identity when they are admitted to the nursing home.

Recently, in the November 2011 issue of AJN, there was an editorial piece on the lack of studies related to LGBT health.² In fact, the Department of Health and Human Services (HHS)³ website states that there needs to be a greater effort to address the health care needs of LGBT individuals. One suggested intervention was to encourage health education programs to include LGBT cultural competencies. Despite the effort to increase LGBT rights in this country, there is still a fear of homophobia and discrimination among the LGBT population, especially in health care.⁴ For instance, a survey done in 1998⁵ showed that nursing students said that 8–12% “despised” LGBT people, 5–12% found them “disgusting,” and 40–43% thought LGBT people should keep their sexuality private.

For this reason, many open LGBT people who lived openly go “back in the closet” when they enter a health care institution. This is especially evident in long term care, where only a brave few will admit their LGBT status to staff and/or other residents. Many LGBT elders hide their sexual identity due to fear that they will not be accepted. There is a fear of persecution for their sexual orientation, feeling that they will be neglected or even mistreated by staff.⁶ Research shows that LGBT persons are twice as likely to be single, and about three times as likely to be childless than their heterosexual peers.⁷ With this loss of social support, many LGBT elders feel alone and abandoned when living in the nursing home.

1. Statistics on the LGBT population

The William's Institute at the UCLA School of Law, which is a LGBT law and policy group, estimates that 9 million (about 3.8%) of Americans identify as LGBT as of 2011. There are many experts that feel these numbers should actually be higher, as there are many LGBT people who do not feel safe reporting their sexual identity to anyone they do not know.⁸

2. The LGBT movement: A brief history

The 1950s were the initial start to the gay rights movement. It first started as gay men and lesbians trying to protect each other against police persecution. In those days, being openly gay was a crime.⁹ Often, gay men and lesbians were labeled as communists or suspected sex offenders to help persecute them in court. For this reason, many LGBT persons developed “codes” so they could identify each other safely, without being open about their sexuality. These included: pinky rings, pink flamingos in the yard, or earrings worn a certain way.

During the 1960's, there was a push for social activism in this country, as evidenced by the Black Power, Women's Liberation, and Anti-War movements in the United States. This increased awareness in minority rights inspired some lesbian, gay, bisexual, and transgender (LGBT) groups to begin the Gay Liberation Movement. This new thinking was put in the forefront during the Stonewall Riots in New York City in 1969, when a group of transsexual, lesbian,

and gay patrons at a bar resisted a police raid.⁹ Although the LGBT movement was already starting, the Stonewall Riots provided a rallying point for the newborn movement. This movement continued to gain force through the 1970s, with the addition of Women's Liberation. Women in the 70s could be strong, outspoken, and do what they wanted. Prior to this, women were looked down upon if they were not mothers or married. Lesbians were felt to be "old maids" to be pitied, because they "couldn't get a man".

By the late 1980s, HIV/AIDS became a national problem, affecting not only the LGBT population, but all types of people. When the AIDS crisis began, as first it was labeled the "gay cancer". There was no test initially, and no one knew what caused it. Many lesbians joined the health leadership to care for gay men, as many health care personnel refused to care for them, out of fear of contracting AIDS themselves. This brought together the lesbian and gay community, as prior to this the movements were considered separate. Today, the LGBT movement continues to make progress. The last sodomy law was removed from books in the 1990's. More recent examples of this include the repeal of "Don't Ask, Don't Tell" by the United States Military, and the acceptance of same sex marriages in some states.

3. Disparities for the LGBT population

Growing up, many LGBT persons have a difficult time, especially when they live in areas that are not accepting of different expressions of sexuality. Many LGBT persons will describe their growing up experience as painful, as when they realize that they are different they try to stay "in the closet", feeling that by being or acting normal, they will be happy. However, this causes a great internal conflict, because their true self is a secret. There is compartmentalization of their real self, as they develop skills to try and fit into mainstream society. Due to this internal conflict, many LGBT persons have anxiety and depression.¹⁰ They are often abandoned by religion and society at large, because many people consider the LGBT lifestyle unnatural, immoral, or a sin.

The LGBT persons who choose to be open about their sexuality describe a feeling of freedom. They feel that they are living as they were meant to be, without fear of acceptance by mainstream society. At this time, many LGBT communities throughout the country have flourished, enabling an open lifestyle without fear of rejection.

Unfortunately, as people age in the United States, the acceptance of the LGBT lifestyle does not continue.¹¹ For instance, there are federal programs that are supposed to provide elder health care and other services, but many federal programs and laws treat same-sex couples differently from married heterosexual couples.¹² For example, Social Security will pay survivor benefits to widows and widowers, but this does not include a same-sex life partner. Also, Medicaid regulations protect the assets and homes of married spouses when the other spouse enters a nursing home. However, no such protections are offered to same-sex partners. Lastly, hospital visitation can be denied to same-sex partner, since they are often not legally married or considered next of kin.¹³

Due to this disparity, some activists have created LGBT-specific service organizations for the aged, including Services and Advocacy to Gay, Lesbian, and Transgender Elders (SAGE) and Pride Senior Network. However, these types of programs are not available in all areas of the United States.

4. Issues for LGBT in long term care (LTC) institutions

Many LGBT patients go back "in the closet" upon entering a nursing home, even if they were previously open. Upon intake, LGBT partners often become "close friends". If their partner has

health care decision-making capabilities, they are listed in the chart as a decision maker, rather than a significant other. Others who have not had their partners named as decision makers have to deal with their children or families making decisions without the involvement of their significant others.

Transgender persons have an especially hard time in institutions.¹⁴ Many health care staff will make jokes or openly voice disapproval of their lifestyle. Sometimes, staff has no idea how to approach them or to even what to call them when they are addressing them.

We must keep in mind that many of the staff in nursing homes include minorities from countries where the LGBT culture is not accepted. But, these caretakers are not the only people in the nursing home poorly educated in taking care of LGBT persons. There is a lack of LGBT curriculum for both nurses and physicians in this country.⁵

5. General health issues in the elder LGBT population

Research has demonstrated that LGBT persons have the same basic health needs as everyone else. However, they also experience a discrepancy in their health care coverage due to barriers to their lifestyle. Keeping this in mind, it is important to establish trust with your LGBT patients, or otherwise they will not actively seek out health care.

6. Mental health issues

Due to the discrimination of the LGBT culture in many areas of the world, mental health appears worse amongst LGBT persons, with incidences of depression, anxiety and suicidal ideation being 2–3 times higher than the general population.¹⁰ They may turn to substances like tobacco, alcohol, and illicit drugs at a higher rate than the general population to try and cope with their emotional issues.

7. Lesbians

Lesbians have the richest concentration of risk factors for breast cancer and other gynecologic cancers, as many choose to remain childless.⁷ Research confirms that lesbians are more likely to be obese than heterosexual women. Obesity is associated with higher rates of heart disease and certain cancers. Furthermore, domestic violence can still occur in about 11 percent of lesbian homes, so screening for domestic violence should still be done with lesbian patients as well.

8. Homosexual men

Men who have sex with men (MSM) are at an increased risk of HIV infection, sexually transmitted diseases (STDs), and Hepatitis.¹⁵ There is absolutely no doubt that safe sex reduces the risk of STDs, so prevention of these infections through safe sex is very important. The introduction of retroviral drugs has made HIV a chronic disease now, so there has been an increase in unsafe sex practices among MSM. Of all the sexually transmitted infections gay men are at risk for, human papilloma virus (HPV), which cause anal and genital warts, is often thought to be a mere inconvenience. However, these infections may play a role in the increased rates of anal cancers in gay men.¹⁵ Some health professionals now recommend routine screening with anal Pap Smears, similar to the test done on a cervix, to detect early anal cancers.

Lastly, many gay men have issues with poor body image. There can be abuse of steroids and certain supplements to gain muscle strength, as well as a tendency to exercise excessively. As a result, gay men are much more likely to have an eating disorder, such as

bulimia or anorexia nervosa. Conversely, there is also a small subset of the gay community that is obese.

9. Transgender (TG)

TGs may hide important details of their health history from their health care providers. There is tremendous fear of being judged or mistreated by uninformed health care personnel. Due to taking hormones to get desirable feminine/masculine effects, being TG carries unique risks.¹⁴ Estrogen has the potential to increase the risk of breast cancers, blood clotting and high blood pressure. Testosterone can cause strokes, heart attacks, and even liver damage with high doses. This is why it is especially important that hormone use should be appropriately monitored by a skilled health care provider. Some trans-women have had injectable silicone to give them a softer, less masculine appearance. If done by someone unskilled, this can cause disfigurement or other health issues, especially if non-medical grade silicone is used (contaminants may be present).⁷

If someone has not had their reproductive organs removed through gender reassignment surgery, they still need to be screened for cancers of these organs. For instance, TGs with an intact prostate may be at less risk of prostate cancer due to estrogen effects, but there is still a risk. Mainstream society often finds TGs unacceptable, which leads to increased use of alcohol and increased risk of suicide.⁵ Tobacco use is high among all TG, especially when used as a weigh control aid.¹⁶

10. Helping your LGBT patients feel more accepted

To help create a welcoming environment to LGBT persons, there are many things that can be done. First, nursing homes should develop protocols for respectful verbal communication that demonstrate sensitivity to LGBT patients and their families. An example of this would be to have the intake forms list “relationship status” instead of marital status. Another example of this would be, “please let us know your gender” rather than “male or female?”⁵

Visitation rights for LGBT partners are critical, and should be part of any LGBT friendly policy. It is important to help make the significant other/partner part of the team and decision making process, even if they are not listed as the health care decision maker. Partners/significant others of LGBT persons should also be listed as such in the medical chart.

Educational staff should provide a targeted training program to encourage more LGBT-inclusive protocols into their daily routines.¹⁶ This training should include using more welcoming language and sensitive responses to those patients who identify as LGBT. It would also help to discuss patient's rights to confidentiality and respect, no matter their lifestyle choice.⁶ This type of training should include all levels of staff, from housekeepers to administration, so that each facility has a total welcoming atmosphere for all LGBT individuals.

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